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ATTN: Kayla Bryant

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FROM: Jay Steck

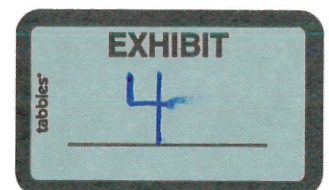
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RE: Death Certificate for James Steele

COMMENTS: _____

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HAMILTON COUNTY
HEALTH DEPARTMENT
CERTIFICATE OF DEATH

DATE JAN 26 2018

Local No 000121

1. Decedent's Legal Name (First, Middle, Last) JAMES ERNEST STEELE				1a. Maiden Name (If Female)		2. Sex MALE	3. Time Of Death 07:00 PM	4. Date Of Death (Month/Day/Year) 01/23/2018
5. Social Security Number REDACTED	6a. Age - Yrs 76	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) REDACTED	8. Birthplace (City and State or Foreign Country) BOSTON, MA	
9. Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival			10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)			
11. Facility Name (If Not Institution, Give Street and Number) 4187 PEARSON DRIVE								
12. City Or Town, State, And Zip Code WESTFIELD, IN, 46062				13. County Of Death HAMILTON		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name			15a. Last Name Before First Marriage			16. Decedent's Usual Occupation OWNER		17. Kind Of Business/Industry CONSTRUCTION
18. Residence - State INDIANA		18a. County HAMILTON		18b. City Or Town WESTFIELD		18c. Apt. No.		18d. Zip Code 46062
18e. Street And Number 4187 PEARSON DRIVE						18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
19. Decedent's Education BACHELOR'S DEGREE (BA, AB, BS)		20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White				
22. Parent's Name (First, Middle, Last) JACK STEELE				23. Parent's Name (First, Middle, Last) ANNE STEELE		23a. Parent's Last Name Before First Marriage LAMBERT		
24. Informant's Name JOY STEELE		24a. Relationship To Decedent DAUGHTER		24b. Mailing Address (Street And Number, City, State, Zip Code) 1533 WHISPERING CREEK DRIVE, BALLWIN, MO 63021				
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) ARN CREMATION SERVICES		25c. Location - City, Town, And State ZIONSVILLE (HAMILTON CO), IN				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility AARON-RUBEN-NELSON, 11411 N. MICHIGAN ROAD, ZIONSVILLE (HAMILTON CO), IN 46077				27a. Funeral Home License Number FH10900017		
27b. Signature Of Indiana Funeral Service Licensee: DONNI LOTZ, BY ELECTRONIC SIGNATURE				27c. License Number (Of Licensee): FD21200037				
Cause Of Death (See Instructions And Examples)								
28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.								
Immediate Cause (Final Disease Or Condition Resulting In Death)				A. ACUTE ON CHRONIC SYSTOLIC HEART FAILURE <small>Due to (Or As A Consequence Of):</small>				
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last				B. <small>Due to (Or As A Consequence Of):</small>				
				C. <small>Due to (Or As A Consequence Of):</small>				
				D. <small>Due to (Or As A Consequence Of):</small>				
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I HX OF MYOCARDIAL INFARCTION, AFIB				29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year		33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined				
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number		38c. Apt. No.		38d. Zip Code
39. Describe How Injury Occurred				40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)				
41. Signature, Of Person Certifying Cause Of Death: CLAIRE WILLARD, BY ELECTRONIC SIGNATURE				42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: CLAIRE WILLARD, 720 ESKENAZI AVE., INDIANAPOLIS, IN 46202				44. License Number: 01073130A			45. Date Certified 01/26/2018	
46. Additional Funeral Service Provider:				47. *AKER:				
48. Signature Of Local Health Officer: CHARLES HARRIS, VIA ELECTRONIC SIGNATURE				49. For Registrar Only - Date Filed (Month/Day/Year): JAN 26 2018				
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)								